Medical services supply measurement

A case for access modeling

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The views expressed in this editorial are those of the authors and do not necessarily reflect the opinion or position of the Ontario Medical Association.

Traditionally, policy makers have used physician-to-population ratios as key determinants for physician human resource planning. The use of physician-to-population ratios as a means of assessing the adequacy of the supply of medical services has many problems, including their inability to account for complementary inputs to medical services, changing physician productivity, and population dispersion.[1] More troublesome, perhaps, is the very superficial link between physician-to-population ratios and the health needs of the populace. Nevertheless, governments continue to rely heavily on physician-to-population ratios for establishing policy measures aimed at changing the number, specialty mix, and geographic distribution of physicians.

The acceptance of this tool for planning purposes, despite its flaws, is perhaps not surprising given that it has an intuitive appeal and an ease of use that make it attractive to health care planners. As a result, in Ontario, physician-to-population ratios have been used to decide policy on the numbers of physicians, to determine exemptions under the Specialist Retention Initiative, and most recently, by the government to identify "oversupplied" areas of the province in which new physicians are to be paid discounted fees and have lowered billing thresholds.[2] In the latter situation, government relied heavily on physician-to-population ratios at the municipal level for general and family practice (GP/FP) services, and county-based physician-to-population ratios for specialty services.

Building a physician databank

The Ontario government relies on physician-to-population ratios produced by the Royal College of Physicians and Surgeons of Canada (RCPSC) and the Council of Ontario Faculties of Medicine (COFM) as targets or benchmarks.[3,4] The RCPSC ratios were established for specialists and were the product of the National Specialty Physician Review. The objectives of the National Specialty Physician Review were to validate the Canadian Medical Association's Physician Resource Databank and so create a base reference for physician planning, and to review the recommended physician-to-population ratios contained in the 1985 Report of the Federal/Provincial Advisory Committee on Health Manpower.[5]

The base year for the analysis was 1986, and even if the ratios do reflect 1986 base-year requirements, which is highly debatable, there is no reason to expect that those ratios are relevant today, more than a decade after the fact. Indeed, the COFM ratio for GPs/FPs was established in 1981! Nevertheless, it is still being used today to determine physician requirement targets under the Ontario government's Underserviced Areas Program.

Common to both the RCPSC and COFM approaches is the measurement of the health care needs of the population. This has proven extremely difficult, and planners have tended to rely on correlates of need, such as age and sex, and aggregate measures, such as standardized mortality rates. Unfortunately, correlates explain only a small proportion of health care need and are not very helpful in determining specialty-specific requirements because the further correlates are broken down into sub-categories of requirements, the more poorly they perform.[6]

Attempts have been made to measure population needs directly, but this is a daunting task and subject to such variation in opinion about what is likely to happen to such areas as disease trends, physician productivity, the role of allied health care personnel, and new technology that it is unlikely to produce a result that will be generally accepted. Projections of resource requirements are extremely sensitive to assumptions made regarding each of these variables.

What are the choices?

If it is difficult to measure needs directly, if correlates perform poorly, and if full-time-equivalent measures are suspect,[7] what other choices do planners have? Our solution is to pursue what we call access modeling. The foundation upon which our proposal has been built lies in spatial planning, in which systems are structured to accommodate prescribed levels of access to health care services. A good, if somewhat broad example of this, is the Patient Charter established in the United Kingdom. What our proposal offers, which we believe is unique, is the application of spatial planning to the question of oversupply or undersupply of health care services, in general or specific to individual specialties and regions.

Rather than struggling with the impossible task of measuring the demand for all health care services and the level of supply required to satisfy that demand (ie, quantifying physician resource requirements), we suggest instead defining minimum levels of access to a core of services selected to "define" supply in each specialty in each region and then measuring actual access against those levels of access to which the health care system should at a minimum conform.

Access modeling differs from approaches using public health objectives, where planners would specify treatment, immunization, or screening targets (although in the end they might have similar effects). The

approach, generally, would be to convene expert panels for each clinical specialty group, in effect, specialty-specific consensus forums whose members would be geographically and otherwise representative of the practice of that specialty. Those groups would identify key or benchmark conditions or procedures that broadly reflect the practice in their specialty. For each condition or procedure, the panel would be asked to specify the minimum acceptable level of access to it and to its complementary inputs. Those standards and the type of resources that should be made available would likely vary depending upon whether patients were located in urban, rural, or remote regions.

The result would be to create a template that would define "minimal performance standards" for the health care system. Against this, current levels of access or performance could be measured by region and specialty within each region, against the standards. If those standards were not met in a particular region and for a particular specialty, further study would have to take place before the cause of the deficiency were known. For example, the shortage could be because of a shortage of specialists in the area, or it might be due to a shortage of prosthetics or institutional resources. Analogously, areas where access is deemed to be too high in relation to the resources available overall, could also be identified.

Minimal performance standards could be as imprecise as defining maximum waiting times for nonurgent, urgent, and emergency conditions, to something as specific as a guideline. For example, the single most frequent condition presenting to physicians is upper respiratory tract infections (URTI).[8] The minimal performance standard could be as follows:

1. Children younger than 2 years of age with any fever and symptoms of URTI should be seen within 12 hours.
2. Patients older than 65 years or any patients with concomitant illness, such as diabetes, asthma, cystic fibrosis, AIDS, emphysema, or valvular heart disease, should be seen within 12 hours.
3. Patients with fever, URTI, headache, and stiff neck should be seen within 12 hours.
4. Any healthy child or adult with a fever of more than 39°C (102°F) and URTI should be seen within 24 hours.
5. Any healthy child or adult who has no fever or a temperature lower than 38.8°C (100°F) should be seen within 48 hours.
6. Elderly and high-risk patients should receive an influenza vaccination in early fall.
7. Access to a specialist or emergency department should be available within 12 hours for children younger than 4 years with a fever higher than 40°C (104°F); for children with otitis media unresponsive to antibiotics for 4 days; or for anyone suspected of having pneumonia, meningitis, pleurisy, or bacterial endocarditis.

Differing minimum standards of access

Using the above example, the model would endorse guidelines for predominant conditions presented by specialty, guidelines that reflect the minimum level of resources that should be made available to patients and, by extension, medical service supply requirements. Access to needed resources would be measured against those minimal standards to determine conditions of undersupply. The above could also specify maximal performance standards as well, in which case the approach could be used to determine oversupply.

Of course, differing minimum standards of access could be developed by different groups, but the front-runners are the medical profession and government. It would be difficult to see these standards as anything but being evidence based, but beyond this, the likelihood of complete congruence is remote. Government will consider standards with a sharp eye on costs and competing programs. The profession will consider minimum standards based on health outcomes.

The advantage of our suggested approach is that it measures access directly rather than relying upon proxies, such as full-time-equivalent counts based on billings, which can only approximate access. Furthermore, access measures are more precise in that they can be directed toward specific treatments. Finally, because the access measures can be directed toward specific treatments, the approach allows governments and policy planners to assess and refine the effectiveness of health policy initiatives, which gives them the information they need to intervene when health policy objectives are not being met.

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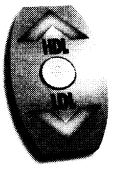

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Initial therapy for hyperlipidemia should include a specific diet (at least an equivalent of the American Heart Association (AHA) Step I diet), weight reduction, and an exercise program; and for patients with diabetes mellitus, good diabetic control. **CONTRAINDICATIONS:** 1. Hepatic or severe renal dysfunction (creatinine clearance < 20 mL/min), including primary biliary cirrhosis. 2. Preexisting gallbladder disease (see WARNINGS). 3. Hypersensitivity to fenofibrate, or other drugs of the fibrate class. 4. The drug should not be used in pregnant or lactating patients. 5. LIPIDIL and LIPIDIL MICRO (fenofibrate) are not indicated for the treatment of Type I hyperlipoproteinemia. **WARNINGS:** 1. **Drug interactions:** ***Concomitant anticoagulants:*** Caution should be exercised when anticoagulants are given in conjunction with LIPIDIL or LIPIDIL MICRO (fenofibrate). The dosage of anti-coagulant should be reduced to maintain the prothrombin time at the desired level to prevent bleeding complications. Careful monitoring of prothrombin time is therefore recommended until it has been definitely determined that the prothrombin level has been stabilized. ***Statins and cyclosporine:*** Severe myositis and rhabdomyolysis have occurred when a statin or cyclosporine was administered in combined therapy with a fibrate. Therefore, the benefits and risks of using fenofibrate concomitantly with these drugs should be carefully considered. ***MAO-inhibitors:*** MAO-inhibitors with hepatotoxic potential must not be administered together with fibrates such as fenofibrate as they may increase the risk of hepatotoxicity. ***Sulphonylureas and insulin:*** It has been previously reported that the fibrates may potentiate the effects of these classes of drug. This effect has not yet been documented in the case of fenofibrate. No case of hypoglycemia or hypoglycemic reaction has been reported to date. 2. **Pediatric use:** Limited experience is available in children and adolescents, at the dose of 5 mg/kg/day non-micronized formulation. However, safety and effectiveness has not been established in this sub-population (see selected bibliography). 3. **Use in pregnancy:** Strict birth control procedures must be exercised by women of childbearing potential. If pregnancy occurs despite birth control procedures, LIPIDIL or LIPIDIL MICRO should be discontinued. Women who are planning pregnancy should discontinue LIPIDIL products several months prior to conception. 4. **Nursing mothers:** In the absence of information concerning the presence of fenofibrate in human breast milk, LIPIDIL or LIPIDIL MICRO should not be used by nursing mothers. 5. **Cholelithiasis:** Fenofibrate may increase cholesterol excretion into the bile, and may lead to cholelithiasis. If cholelithiasis is suspected, gallbladder studies are indicated. LIPIDIL or LIPIDIL MICRO therapy should be discontinued if gallstones are found. 6. Fenofibrate clinically and pharmacologically shows similarities with clofibrate. Physicians prescribing LIPIDIL products should also be familiar with the risks and benefits of clofibrate. 7. In long term, animal toxicity and carcinogenicity studies fenofibrate has been shown to be tumorigenic for the liver in male rats at 12 times the human dose. At this dose level in male rats there was also an increase in benign Leydig cell tumors. Pancreatic acinar cell tumors were increased in male rats at 9 and 40 times the human dose. However, mice and female rats were unaffected at similar doses. Florid hepatocellular peroxisome proliferation has been observed following fenofibrate administration to rats. Such changes have not been found in the human liver after up to 3.5 years of fenofibrate administration. 8. Since a relationship between reduction of mortality from coronary artery disease and total mortality has not been established, LIPIDIL and LIPIDIL MICRO should be administered only to those patients described in INDICATIONS. If a significant serum lipid response is not obtained in three months, LIPIDIL products should be discontinued. If LIPIDIL or LIPIDIL MICRO is chosen for treatment, the prescribing physician should discuss the proposed therapy and inform the patient of the expected benefits and potential risks which may be associated with long-term administration (see PRECAUTIONS).
PRECAUTIONS: 1. **Initial therapy**: Before instituting fenofibrate therapy, attempts should be made to control serum lipids with appropriate diet, exercise and weight loss in obese patients. Other medical problems, such as diabetes mellitus and hypothyroidism, should also be controlled. In patients at high risk, consideration should be given to the control of other risk factors such as smoking, excessive alcohol intake, hormonal contraceptive use, and inadequately controlled hypertension. 2. **Long-term therapy**: Because long-term administration of fenofibrate is recommended, the potential risks and benefits should be carefully weighed. Adequate pretreatment laboratory studies should be performed to ensure that patients have elevated serum cholesterol and/or triglycerides or low HDL-cholesterol levels. Periodic determination of serum lipids, fasting glucose, creatinine and ALT (SGPT) should be considered during fenofibrate treatment, particularly during the first months of therapy. 3. **Reproduction studies**: Standard tests for teratology, fertility and peri- and post-natal effects in animals have shown a relative absence of risk; however, embryo-toxicity has occurred in animals at maternally toxic doses. 4. **Hematologic changes**: Mild hemoglobin, hematocrit, and white blood cell decreases have been observed occasionally in patients following initiation of fenofibrate therapy. However, these levels stabilize during long-term administration. Periodic blood counts are recommended during the first 12 months of fenofibrate administration. 5. **Liver function**: Abnormal liver function tests have been observed occasionally during LIPIDIL or LIPIDIL MICRO (fenofibrate) administration, including elevations of transaminases, and decreases or, rarely, increases in alkaline phosphatase. However, these abnormalities disappear when therapy with fenofibrate is discontinued. Therefore, periodic liver function tests (AST [SGOT], ALT [SGPT] and GGT [if originally elevated]) in addition to other baseline tests are recommended after 3 to 6 months and at least yearly thereafter. LIPIDIL therapy should be terminated if abnormalities persist. Fenofibrate may increase cholesterol excretion into the bile, and may lead to cholelithiasis. 6. **Hepatobiliary disease**: In patients with a past history of jaundice or hepatic disorder, fenofibrate should be used with caution. 7. **Skeletal muscle**: Treatment with drugs of the fibrate class has been associated on rare occasions with rhabdomyolisis or myositis, usually in patients with impaired renal function. Myopathy should be considered in any patient with diffuse myalgias, muscle tenderness or weakness, and/or marked elevation of creatinine phosphokinase levels. Patients should be advised to report promptly unexplained muscle pain, tenderness or weakness, particularly if accompanied by malaise or fever. CPK levels should be assessed in patients reporting these symptoms, and fenofibrate therapy should be discontinued if markedly elevated CPK levels (10 times the upper limit of normal) occur or myopathy is diagnosed. 8. **Drug interactions** (see also WARNINGS): ***Resins:*** When a fibrate is used concurrently with cholestyramine or any other resin, an interval of at least 2 h should be maintained between the administration of the two drugs, since the absorption of fibrates are impaired by cholestyramine. ***Estrogens:*** Since estrogens may lead to a rise in lipid levels, the prescribing of fibrates in patients taking estrogens or estrogen-containing contraceptives must be critically considered on an individual basis. 9. **Renal function:** In patients with hypoalbuminemia, e.g. nephrotic syndrome, and in patients with renal insufficiency, the dosage of fibrates must be reduced and renal function should be monitored regularly (see PRECAUTIONS, Skeletal muscle and DOSAGE AND ADMINISTRATION). Fenofibrate is not removed by hemodialysis and should not be used in dialysis patients. **ADVERSE REACTIONS:** Clinical adverse effects of LIPIDIL (fenofibrate) therapy have been reported at an incidence between 2 and 15 percent with a mean of 6.3 percent in European trials of less than 12 months duration. In longer term studies, the incidence was between 7 and 14 percent with a mean of 11.3 percent. The most frequently reported adverse effects include: Gastrointestinal: epigastric distress, flatulence, abdominal pain, nausea, diarrhea, constipation. Dermatologic: erythema, pruritus, urticaria. Musculoskeletal: muscle pain and weakness, arthralgia. Central nervous system: headache, dizziness, insomnia. Miscellaneous: decreased libido, hair loss, weight loss. **DOSAGE AND ADMINISTRATION:** The recommended dose for LIPIDIL MICRO (micronized fenofibrate) is one 200 mg capsule daily taken with the main meal. This should not be exceeded. The recommended dose for LIPIDIL (fenofibrate) is 300 mg daily administered in three divided doses (three 100 mg capsules) to be taken with meals. The maximum recommended total daily dose is 400 mg. In patients with renal insufficiency (creatinine clearance between 20 and 100 mL/min), LIPIDIL treatment should be initiated at the dose of 100 mg/day and increased progressively after evaluation of the tolerance and effects on the lipid parameters. LIPIDIL is not removed by hemodialysis and should not be used when the creatinine clearance is lower than 20 mL/min. **AVAILABILITY OF DOSAGE FORMS:** LIPIDIL (fenofibrate) is available as opaque, white, hard gelatin capsules. Each capsule contains 100 mg of fenofibrate. LIPIDIL is available in bottles of 100 capsules. LIPIDIL MICRO (micronized fenofibrate) is available as orange, hard gelatin capsules. Each capsule contains 200 mg of micronized fenofibrate. LIPIDIL MICRO is available in boxes of 30 capsules.
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La mesure de l'offre de services médicaux

Un cas de modélisation de l'accès aux services

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Les opinions exprimées dans le présent éditorial représentent celles des auteurs et ne reflètent pas nécessairement le point de vue ou la position de l'Association médicale de l'Ontario.

Traditionnellement, on s'est servi du ratio du nombre de médecins par habitant comme critère déterminant dans la planification des ressources humaines médicales. L'utilisation de ce ratio comme mode d'évaluation de la pertinence de l'offre de services médicaux comporte de nombreux problèmes. Il ne tient notamment pas compte des intrants complémentaires aux services médicaux, des fluctuations dans la productivité des médecins et de la répartition de la population[1]. Plus inquiétante encore peut-être est la relation très superficielle qui existe entre le ratio du nombre de médecins par habitant et les besoins réels de la population en matière de santé. Les gouvernements continuent pourtant de se fier considérablement aux ratios du nombre de médecins par habitant dans l'établissement des politiques concernant les modifications au contingentement de médecins, à l'agencement des spécialités et à leur répartition géographique.

En dépit de ses lacunes, il n'est peut être pas surprenant qu'on accepte encore de se servir de cet instrument à des fins de planification, en raison de son attrait intuitif et de sa facilité d'usage pour les planificateurs des soins de santé. Par conséquent, en Ontario, les ratios du nombre de médecins par habitant ont été utilisés pour définir les politiques sur le contingentement de médecins et établir les exemptions en vertu de l'Initiative de maintien de l'effectif des spécialistes. Plus récemment, le gouvernement y a eu recours pour déterminer les régions de la province où l'offre de services est jugée « excédentaire », et où les nouveaux médecins reçoivent des honoraires réduits et se voient fixer un seuil de facturation plus bas[2]. Dans cette récente initiative, le gouvernement s'est fondé principalement sur le nombre de médecins par rapport à la population municipale, dans le cas des services dispensés par les omnipraticiens et les médecins de famille, et par rapport à la population du comté pour les services de spécialistes.

L'élaboration d'une banque de données sur les médecins

Le gouvernement ontarien se sert des ratios du nombre de médecins par habitant, compilés par le Collège royal des médecins et chirurgiens du Canada (CRMCC) et le Council of Ontario Faculties of Medicine (COFM), comme cibles ou jalons[3,4]. Les ratios du CRMCC ont été déterminés pour les spécialistes dans le contexte de la Revue nationale des médecins spécialistes. Cette étude avait pour objectif de valider la banque de données sur les ressources sanitaires de l'Association médicale canadienne. L'exercice permettait ainsi de définir une base de référence sur laquelle fonder la planification des ressources médicales et prendre position relativement au nombre de médecins par habitant recommandé dans le rapport de 1985 du Comité consultatif fédéral-provincial sur la main-d'œuvre sanitaire[5].

On a choisi 1986 comme année de référence. Même si les ratios sont censés refléter véritablement les besoins pour cette année de base, ce qui est loin de faire l'unanimité, il n'est aucunement justifié de s'attendre à ce que ces chiffres soient encore pertinents plus d'une décennie plus tard. En réalité, le ratio du COFM pour les omnipraticiens et les médecins de famille a de fait été établi en 1981! On s'en sert pourtant toujours aujourd'hui pour définir les contingentements de médecins requis en vertu du Programme de services aux régions insuffisamment desservies du gouvernement de l'Ontario.

On retrouve, autant dans l'approche du CRMCC que dans celle du COFM, une mesure des besoins de la population en matière de soins de santé. L'exercice s'est révélé extrêmement difficile. Les planificateurs ont eu tendance à se fier, pour définir les besoins, à des corrélats en fonction de l'âge et du sexe, et d'agrégats comme les taux de mortalité normalisés. Malheureusement, les corrélats n'expliquent qu'une infime portion des besoins en soins de la santé et ne sont pas très utiles pour définir les besoins particuliers aux spécialités. En effet, plus on subdivise les corrélats en sous-catégories, plus ils deviennent insignifiants[6].

On a aussi tenté de mesurer directement les besoins de la population. Cependant, la tâche est si énorme et tellement influencée par de grandes divergences d'opinions, à savoir ce qui surviendra dans des domaines comme les tendances pathologiques, la productivité des médecins, le rôle du personnel paramédical et les nouvelles technologies, qu'il est improbable qu'elle produise des résultats qui soient généralement acceptés. Les projections sur les besoins en ressources sont extrêmement vulnérables aux hypothèses faites sur chacune de ces variables.

Les choix offerts

S'il est difficile de mesurer directement les besoins, si les corrélats ne donnent pas les résultats escomptés et si la mesure des équivalents à temps plein est douteuse[7], quel choix s'offre alors aux planificateurs? Notre solution est d'effectuer ce que nous appelons la modélisation de l'accès aux services. Nous avons fondé cette proposition sur la planification spatiale, dans laquelle les systèmes sont structurés pour répondre à des niveaux précis d'accès aux services de la santé. La Charte des droits du patient, adoptée au Royaume Uni, en donnerait un bon exemple,

quoique plutôt général. Ce qu'offre notre proposition et que nous jugeons unique, c'est d'appliquer la planification spatiale à la question de l'offre excessive ou insuffisante des services de santé en général et plus précisément en fonction des spécialités et des régions.

Plutôt que de lutter avec la tâche impossible de mesurer la demande pour tous les soins de santé et le niveau d'offre requis pour satisfaire à la demande (c.-à-d. quantifier le nombre de médecins requis), nous suggérons plutôt de définir des critères d'accès minimal à un ensemble de services choisis pour « définir » l'offre dans chaque spécialité, dans chaque région, puis de mesurer l'accès réel en fonction de ces critères d'accès minimal auxquels devrait se conformer le système de santé.

La modélisation de l'accès se distingue des approches qui se fondent sur les objectifs en matière de santé publique, selon lesquelles les planificateurs précisent des objectifs en matière de thérapie, d'immunisation ou de dépistage (bien qu'en fin de compte, elle en arrive à des résultats similaires). Dans l'ensemble, l'approche serait de rassembler un groupe d'experts dans chacune des spécialités cliniques, c'est-à-dire des tribunes unanimes représentatives de la spécialité, dont les membres refléteraient aussi les différences géographiques ou autres dans l'exercice de leur spécialité. Les groupes définiraient les conditions ou interventions essentielles ou standard que comporte globalement l'exercice de leur spécialité. Pour chaque condition ou intervention, on demanderait aux experts de définir le niveau d'accès minimal acceptable aux services et à ses intrants complémentaires. Ces normes et le type de ressources qui devraient être accessibles varieraient fort probablement selon la région où vivent les patients, qu'elle soit urbaine, rurale ou éloignée.

On se servirait des résultats pour créer un gabarit définissant les « normes minimales de rendement » du système de la santé. À l'aide du gabarit, on comparerait les niveaux actuels d'accès ou de rendement, selon la région ou la spécialité dans chacune d'elle, en fonction des normes. Si les normes n'étaient pas respectées dans une région ou une spécialité, il faudrait réaliser une étude plus approfondie pour en savoir la cause. Il se peut que l'écart vienne d'une pénurie de spécialistes dans la région ou encore d'un manque de ressources en prothétique ou sur le plan institutionnel. Parallèlement, on pourrait aussi identifier les régions où l'accès est trop élevé par rapport aux ressources disponibles globalement.

Les normes minimales de rendement peuvent être aussi générales que la définition du temps d'attente maximal pour les cas non urgents, les cas urgents et les cas d'extrême urgence, et aussi précises qu'une directive. Par exemple, les cas les plus fréquents que voient les médecins sont les infections des voies respiratoires[8]. On pourrait définir comme suit la norme de rendement minimal:

1. Les enfants de moins de deux ans qui font de la fièvre et présentent des symptômes d'infection des voies respiratoires devraient voir le médecin dans les 12 heures.
2. Les patients de plus de 65 ans ou ceux souffrant de maladies concomitantes, comme le diabète, l'asthme, la fibrose kystique, le sida, l'emphysème ou les cardiopathies valvulaires, devraient être vus dans les 12 heures.
3. Les patients souffrant de fièvre, d'infection des voies respiratoires, de maux de tête et de raideurs au cou devraient être vus dans les 12 heures.
4. Les personnes normalement en santé, enfants ou adultes, dont la température s'élève à plus de 39°C (102°F) et souffrant d'infection des voies respiratoires, devraient être vus dans les 24 heures.
5. Les enfants ou les adultes normalement en santé dont la température s'élève à moins de 38,8°C (100°F) devraient être vus dans les 48 heures.
6. Les personnes âgées et les patients à risque devraient recevoir un vaccin contre l'influenza au début de l'automne.
7. L'accès à un spécialiste ou à l'urgence devrait être possible dans les 12 heures pour un enfant de moins de 4 ans qui fait plus de 40°C (104°F) de fièvre; pour les enfants souffrant d'otite moyenne qui ne répondent pas à un traitement aux antibiotiques suivi depuis 4 jours; ou pour les personnes soupçonnées souffrir de pneumonie, de méningite, de pleurésie ou d'infection bactérienne endocardiaque.

La non-conformité aux normes minimales de rendement

Suivant l'exemple énoncé ci-haut, le modèle adopterait des directives concernant les principaux cas qui se présentent selon la spécialité. Les directives refléteraient le niveau minimal d'accès aux ressources qui devrait être offert aux patients et définiraient par ricochet les besoins en services médicaux. On mesurerait l'accès aux ressources nécessaires en fonction des normes minimales pour cerner les cas d'insuffisance de services. On pourrait également définir des normes maximales de rendement, qui serviraient alors à déterminer les services excédentaires.

Bien sûr, d'autres groupes pourraient définir les écarts acceptables dans l'accès aux services, mais les chefs de file dans ce domaine ne sont-ils pas les membres de la profession médicale et le gouvernement? Il serait donc difficile de ne pas considérer ces normes comme étant fondées sur des données probantes. Malgré tout, la probabilité d'un consensus à cet égard est bien faible. Le gouvernement étudiera ces normes rigoureusement en fonction des coûts et de la concurrence entre les programmes. La profession médicale fondera sa position sur les normes minimales en fonction des résultats en matière de santé.

L'avantage que comporte l'approche que nous suggérons vient du fait qu'on

mesure directement l'accès plutôt que de se fier à des indices, comme le calcul des équivalents à temps plein à l'aide de la facturation, qui ne représentent qu'une approximation de l'accès. De plus, la mesure de l'accès est plus précise si elle peut être faite en fonction de traitements bien précis. Enfin, parce que la mesure de l'accès peut se fonder sur des traitements précis, cette approche permet aux gouvernements et aux planificateurs d'évaluer et de raffiner les initiatives de politiques en matière de santé, car ils ont en main les renseignements dont ils ont besoin pour intervenir lorsque les objectifs ne sont pas atteints.

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